UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

BRAND NAME MEDICATION

Patient name:_____Medicaid ID #:_____

Prescriber Name:_____Prescriber NPI#:_____ Contact person:_____

Prescriber Phone#:_____Extension/Option:_____ Fax#:_____

Pharmacy:_____Pharmacy Phone#:_____Pharmacy Fax #:_____

Requested Medication:_____Pharmacy NPI#:_____Strength:_____Frequency/Day:_____

All information to be legible, complete and correct or form will be returned

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FAX DOCUMENTATION FROM PROGRESS NOTES TO 855-828-4992

CRITERIA:

- Explanation of why treatment was initiated with the branded product OR
- Details of adverse reaction, allergy or inadequate response to the generic equivalent

NOTES:

- Many extended-release branded products do not have extended-release generic equivalents. In these cases, an adequate trial of the short-acting generic product is required.
- Prior authorizations for brand name medications require physician evaluated, charted documentation of an allergic reaction or adverse reaction. Patient complaints of lack of efficacy are not acceptable reasons for failure such as “Client said”, “client reports”, “doesn’t work” or “causes nausea.”
- This Prior Authorization is only available to clients enrolled in Traditional Medicaid (Purple Card). Clients enrolled in Non-Traditional Medicaid (Blue Card) or Primary Care Network (Yellow Card) must pay full price for brand name medications with available generics.

AUTHORIZATION:
One year

RE-AUTHORIZATION:
Updated letter of medical necessity

04/20/2012

http://health.utah.gov/medicaid/pharmacy